SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Using Data to Improve Care

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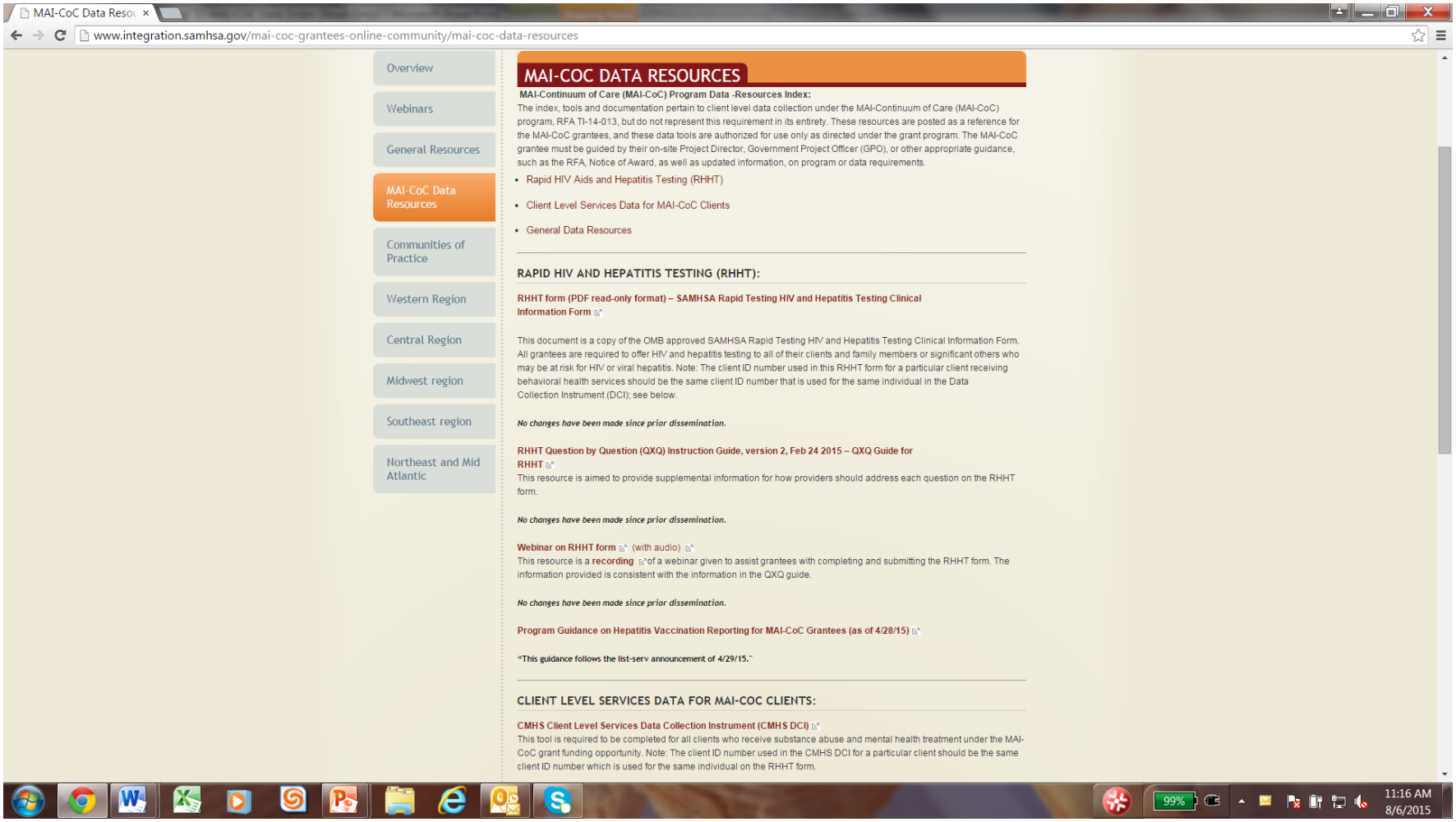
Agenda

- Identifying target audiences of data
- Understanding methods to move information from aggregate to granular level (and vice-versa)
- Incorporating project dashboards and consumer wellness reports into continuous quality improvement (CQI)

Group Discussion

- Which staff in your organization care about project data?
- What specific information are they interested in?
- Is the data they are interested in aligned with MAI-CoC data collection requirements?
- Why are they interested in this data?

MAI-CoC Data Resources Tab at *integration.samhsa.gov*



Reporting for External Funders, Board of Directors, Administrators

They want to see….

- Cost savings
- Health improvement

COST SAVINGS

(YEAR ONE)

Missouri Health Homes have saved **$30,996,642.**

REDUCTION IN
HOSPITALIZATIONS
IN THE FIRST YEAR

9.1%

(CMHC HEALTH HOME CLIENTS)

Missouri Coalition for Community Behavioral Healthcare, Mar 2015.

DIABETES

3-YEAR OUTCOMES
(FEB 2012 - JAN 2015)

Good Cholesterol
↑ 37%

Normal Blood Pressure
↑ 42%

Normal Blood Sugar
↑ 46%

HYPERTENSION & CARDIOVASCULAR DISEASE

3-YEAR OUTCOMES
(FEB 2012 - JAN 2015)

Good Cholesterol
(Clients with CVD)
↑ 34%

Normal Blood Pressure
(Clients with HTN)
↑ 41%

Missouri Coalition for Community Behavioral Healthcare, Mar 2015.

Reporting for Program Administrators

They want to see….

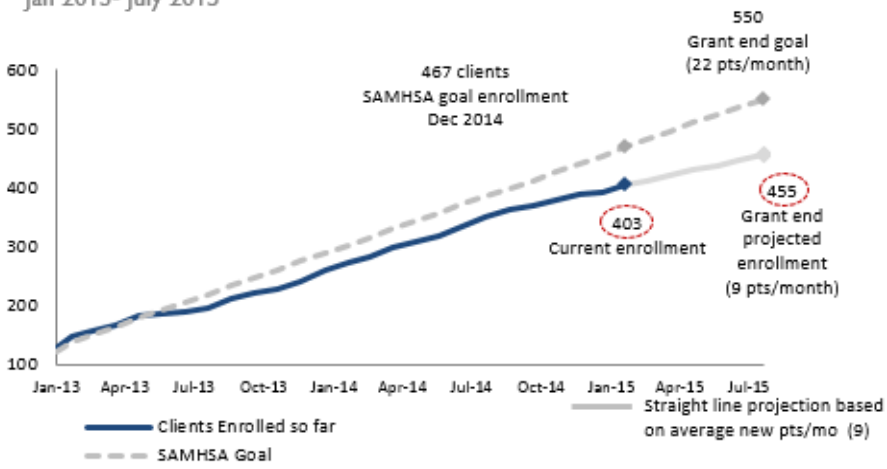
- Enrollment rates
- Screening rates
- Prevalence of risk factors
- Risk factor improvement rates (consider disparities!)
- Grant requirements

South of Market Mental Health Primary Care Clinic
Process Dashboard, January 31st 2015

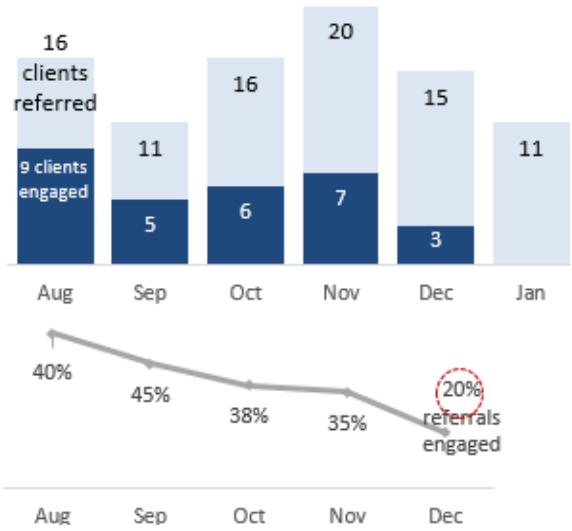
403
total clients enrolled

68%
active clients
273 active, 130 discharged

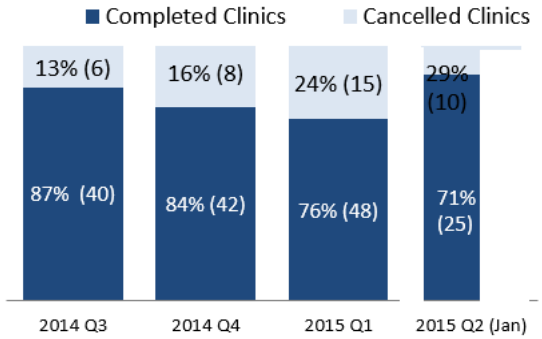
Patients enrolled vs SAMHSA Goal[3]
Jan 2013- July 2015



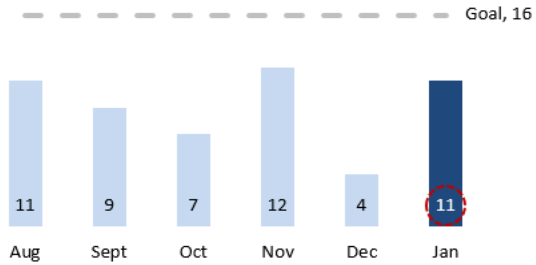
Engagement rate & Referral count
Jun - Dec 2014



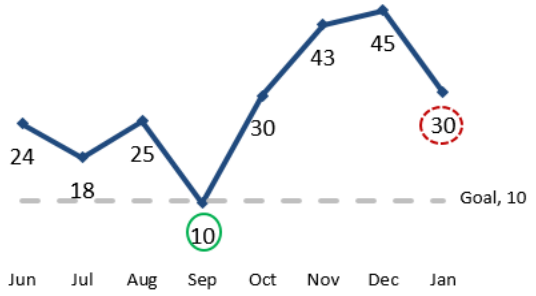
Completed vs. Cancelled Clinics



New Primary Care patients
July - Jan 2014



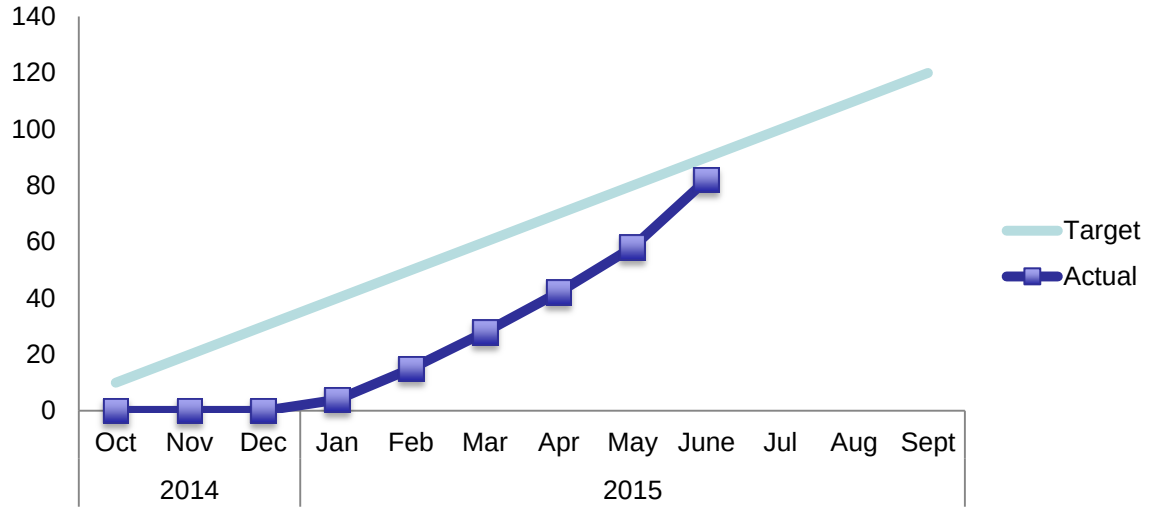
Days to first appointment, new clients[6]
May - Jan 2014



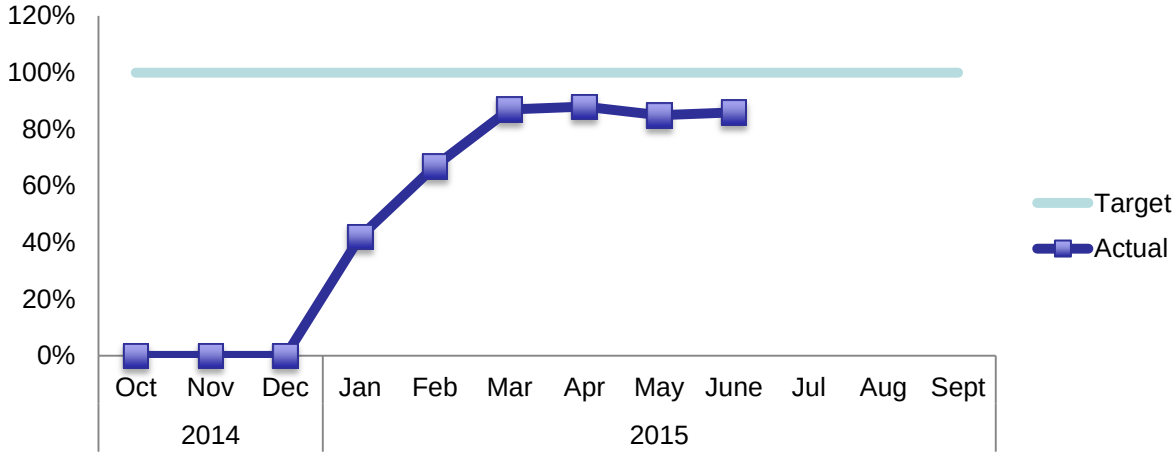
= area of success
= area of concern


MONTHLY GOAL
15
NEW PATIENT REFERRAL
NEW PATIENTS
June
14
New Patients
REFERRALS MADE
18
MAY
12
New Patients
DEPARTMENT OF PUBLIC HEALTH
NOW WE ARE ONE
ONE HELP DESK - ONE NUMBER
LIVE
May 12th
759-3577
24/7 Support For:
Goal Reached!!

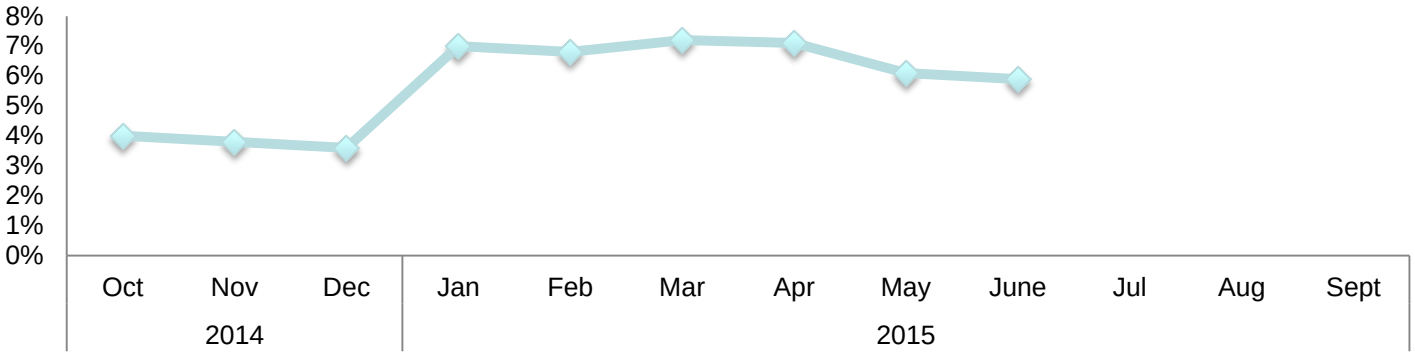
MAI-CoC Enrollment: Actual vs Target



Percent of People with Positive HIV Screens Who Were Prescribed ART - Actual vs Target



HIV Survivorship Rate: Deaths From Complications Related to AIDS over Last 12 Months / Open Cases of People Who Are HIV+ In Last 12 Months



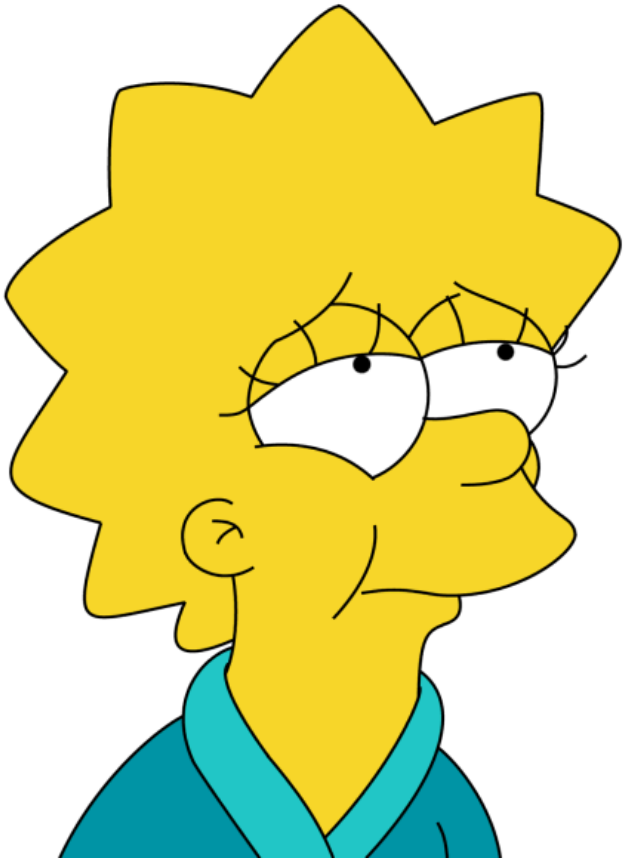
Group Discussion

- What do you want on your program dashboard?
- How does it align with grant data collection requirements?
- What data exceeds grant requirements?
- Why is this data important?
- Who needs to view this dashboard?
- How can you use it to track progress?

Reporting for Consumers

They want to see….

- Health status
- Person-centered plan target metrics
- Crisis plan
- Healthcare coordination



Glenn County Health Care Collaborative
INDIVIDUAL WELLNESS REPORT

Name: **Bea Well**
Clinician: **John Smith**
Case Manager: **Jane Doe**

Normal*
Caution
At Risk

Progress on Key Health Indicators

Category	Indicator (Goal)	Baseline *August 2011*	6-Month Reassessment *February 2012*	12-Month Reassessment *July 2012*
Lungs	Breath CO (0-6)	25	8	5
Weight	BMI (18.5-24.9)	25.8	28.1	25.3
	Weight	162.0	174.0	158.0
	Waist Circumference	35.5	31.5	32.2
Blood Pressure	Systolic BP (90-140)	133	135	114
	Diastolic BP (60-90)	80	75	80
Blood Sugar	Fasting Glucose (70-99)	115	-	115
	Hemoglobin A1C (4.0-5.6)	5.4	-	5.4
Heart Health	Total Cholesterol (125-200)	197	-	189
	LDL Cholesterol (20-129)	111	-	103
	HDL Cholesterol (40+)	76	-	73
	Triglycerides (30-149)	52	-	64

Client Wellness Goal(s):

Bea Well will lose 5 pounds within 6 months.

Bea Well will maintain her excellent progress in reducing/stopping her tobacoo use.

Client Mental Health Goal(s):

Bea Well will sleep at least 7 hours each night to decrease symptoms of depression.

Action Step(s):

Bea Well will walk for 20 minutes five days per week.

Bea Well will eat at least 3 servings of vegetables every day.

Bea Well will go to bed by 10 pm at least 5 nights per week.

Client Signature: *Bea Well* ***Staff Signature:*** *John Smith* ***Date:*** *9/15/2012*

Group Discussion

- What do you want on your individual wellness reports?
- How does it align with grant data collection requirements?
- Why is this data important?
- Who needs to view it?
- How can you use it to track progress?

Sources for Data Elements

- Centers for Medicaid and Medicare Services
- National Committee for Quality Assurance
- AHRQ
- Institute for Healthcare Improvement
- Grant requirements
- Finance department
- Your peers

Data Visualization Resources

- Stephanie Evergreen – stephanieevergreen.com
- Edward Tufte – edwardtufte.com
- American Evaluation Association – comm.eval.org/DataVisualizationandReporting/home
- Data Fluency: Empowering Your Organization with Effective Data communication by Gemingnani

Any Final Questions?